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ABSTRACT

This ERIC Digest explores issues connected with AIDS/HIV education in public K-12 education by addressing five concerns: (1) Why are teenagers at risk? (2) What should be taught when? (3) Who should teach it and in what department? (4) How should teacher training prepare teachers to handle classroom, inservice, and community outreach HIV educational programs? (5) How can school boards avoid or deal with controversy? If comprehensive health education has been effective in reducing smoking and teen pregnancies, this Digest concludes that AIDS/HIV education may reduce this disease's incidence. (JAM)

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AIDS/HIV EDUCATION

By Lynn Balster Liontos

If AIDS education hasn't already been mandated by your state, it may be soon. Increasingly, school administrators and board members will feel pressure to implement HIV* education programs. Teenagers are one of the highest at-risk groups, and, as John Washburn, a former superintendent who has AIDS, has pointed out (Kathleen McCormick 1989), education is the only vaccine we presently have against HIV.

When administrators begin to approach this issue, however, they often find themselves aswirl in controversy. HIV education, because it has to do with community values, religious beliefs, and customs, is a complex and sensitive subject. It involves talking about sex and also about death and dying, topics that make many people feel uncomfortable. In addition, although a growing body of research confirms how HIV is and is not transmitted, there's still a great deal of fear based in misinformation and mistrust. The who, what, when, and how of HIV education are all issues that need to be thoroughly explored and discussed before implementing an HIV program.

Why Are Teenagers at Risk?

Adolescents are considered a high risk group because (1) they're exploring their sexual identities and often are experimenting not only with sex but with drugs; (2) their behavior tends to be impulsive and greatly influenced by peer pressure; and (3) they often feel invulnerable and have trouble seeing long-term consequences. McCormick reports that one out of every five cases of AIDS has occurred among those 20-29 or younger, and because of the long incubation period we now believe that many of these young people were infected as adolescents. Changing the behavior of adolescents, says epidemiologist Helene Gayle (McCormick), is going to make a big difference. Thus the goal of HIV education, according to Centers for Disease Control (CDC) guidelines (Dennis Tolsma and others 1988), is to prevent infection through behavior changes.

What Should be Taught When?

Most critics of HIV education support instruction, but often not at the elementary level. However, many young children have fears about AIDS, and the Surgeon General's report on AIDS stresses the need to educate children at an early age. Mainly they need to be reassured that even though AIDS is a serious disease, it's hard to get.

Most educators believe that specific instruction should begin no later than grade 7 (the age at which many kids are either starting to experiment with sex and drugs—or thinking about it). However, unless your state has a mandated curriculum, the age at which children should learn explicit facts about HIV infection may vary, depending on your community.

Controversy also centers around the issue of stressing abstinence only—or the "Just Say No" approach. The CDC thinks that the "Just Say No" approach isn't enough, especially for those teenagers who, no matter what you say, won't abstain from drugs or sex. The 1988 Gallup Poll revealed overwhelming support for schools to teach "safe sex" as a means of preventing HIV transmission (McCormick).

Both the National School Boards Association (NSBA) and the American Association of School Administrators (AASA) were consulted on the development of the CDC guidelines for comprehensive K-12 education. Most educators agree that one-shot programs are acceptable only if there's no other way for students to get information on HIV infection. As family life educator Claire Scholz puts it: "Most kids don't get it the first time" (McCormick). She thinks the study of HIV prevention should be like the study of U.S. history—taught repeatedly and extending knowledge as students become more sophisticated in their understanding. McCormick lists questions to ask in selecting and evaluating the many curricula currently available (as well as pros and cons on developing your own) and also includes an extensive list of resources, plus information on the CDC's computerized database.

Who Should Teach It—and in What Department?

The CDC guidelines recommend using regular classroom teachers at the elementary level. But with secondary programs most educators, along with the CDC, advocate integrating HIV education into health education. William Yarber (1987) says that HIV infection is fundamentally a public health problem, so the most logical place for it is in the communicable disease unit of a health course: "Such placement makes sense pedagogically because health educators are prepared in methods to help students make wise preventive health decisions, which is the essence of AIDS education." If the program is placed in biology, he fears too much emphasis will be placed on biomedical aspects, or if in social studies, on the social/ethical elements. Also, health education teachers are generally more comfortable dealing with the issues of sexuality and death.

But there are other options. Some school systems use family life specialists, science teachers, or home economics departments; in other districts classes are taught by health

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* Actually the term *AIDS* (the clinical stage of the disease) has become obsolete; *HIV infection* (the state of being infected with the human immunodeficiency virus) more accurately defines the problem; thus this term will be used here on.

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professionals, such as nurses, physicians, or the Red Cross. Several states have linked HIV education with teen pregnancy prevention programs. Finally, the use of peers has been a significant part of HIV programs in some districts. "Peers are much more effective at altering each other's behavior than teachers or other adults," says Dr. Mervyn Silverman ("Issue Scan" 1989).

What about Teacher Training?

Both Katherine E. Keough (1988) and McCormick recommend educating *all* staff—with emphasis on in-service for teachers—before students receive classroom instruction. Staff training might be accomplished through local or state health departments, local hospitals, or a health education specialist. Other questions: Should staff be trained before curriculum decisions are made, or after? Or should they be provided with general HIV education and then specific training once materials are chosen? How will up-to-date information be continually provided?

No matter who is trained to teach HIV education, CDC guidelines emphasize that schools have a responsibility to reach *all* school-age youth. Groups often overlooked include special education students, those who don't speak English, and dropouts or runaways. The latter are usually best reached by working with local youth-oriented agencies. Finally, schools also need to educate parents and the whole community so that they reinforce what schools are teaching.

How Can Controversy Be Avoided or Dealt with?

Develop policies beforehand; don't adopt a "wait and see" approach. There are no foolproof ways for school boards to avoid controversy, says McCormick, but if it's anticipated and planned for, controversy can be managed and constructive.

Focus on process. The process of policy development, for instance, can help resolve disagreements and build consensus and support for HIV education.

Involve the whole community. "Many educators agree that HIV education is more easily accepted," says McCormick, "when the curriculum, materials and activities are developed locally, with the community's needs and values in mind." Do assessments of what your community needs and who's at risk, then work with parents and other groups, including clergy, to reach consensus.

Educate the public. Many school systems credit well-planned public information programs with helping to usher in HIV education without incidence. There are many ways to do this, including community information meetings, letters to parents about HIV and how HIV fits into the curriculum, working with grass-roots organizations, and inviting the community to participate on advisory committees to develop HIV education programs.

Hone your public relations skills. "We think AIDS is the biggest public relations problem we've ever encountered," says National School Public Relations Association Executive Director John Wherry (McCormick). McCormick suggests developing short- and long-range plans for HIV instruction, appointing one spokesperson to deal with press and public inquiries and letting parents, staff, and the community know that curriculum materials are available for review.

Give people time to adjust. Just getting people to talk about HIV education is a first step. You can't reach all the community groups, parents, and teachers and get the kind of support you need to implement a really successful program overnight, says Abelson: "We learn day by day what is needed."

Is it worth it? Can HIV education really be effective? A study on school health education suggests yes (McCormick). Also, comprehensive health education *has* been effective in reducing smoking— and several programs report success in reducing teen pregnancies. As Harvey Fineberg (1988) sums up: "The best we can do in AIDS education offers no guarantee of success. To do less invites failure."

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